BlueCross BlueShield of Nebraska
7261 Mercy Road
Omaha, Nebraska 68180-0001
www.bcbsne.com

Coordination of Benefits (COB)
Omaha 390-1840
Toll Free 800-462-2924

Coordination of Benefits
Fax 402-392-4126
Omaha Main Fax 402-392-2141

NAME:_____

I.D. #:_____

Dear Member:

Your group coverage has a Coordination of Benefits (COB) provision. This provision applies when more than one insurance plan provides benefits. So that we can better serve you, we update our files annually. Please take a few minutes to respond to this questionnaire.

***NO OTHER INSURANCE OR MEDICARE:***
If you or your dependents are **not** covered by any other group or non-group health, dental, prescription drug plan or Medicare coverage, simply check the following box, sign below and return.
☐ No other insurance or Medicare coverage.
I am: ☐ an active employee, ☐ retired. Date of retirement: _____

***IF YOU OR A COVERED DEPENDENT HAS MEDICARE COVERAGE:***
Name of Policyholder: _____ Medicare Number: _____
Part A Effective Date: _____ Part B Effective Date: _____
I have Medicare because: ☐ I am 65 or older, ☐ I am disabled, ☐ I have ESRD.
I am: ☐ an active employee, ☐ retired. Date of retirement: _____

Name of Policyholder: _____ Medicare Number: _____
Part A Effective Date: _____ Part B Effective Date: _____
I have Medicare because: ☐ I am 65 or older, ☐ I am disabled, ☐ I have ESRD.
I am: ☐ an active employee, ☐ retired. Date of retirement: _____

***OTHER INSURANCE:***
If you or your dependents **are** covered by any other group or non-group health, dental or prescription drug plan, or you are responsible for dependent coverage due to a divorce, please complete and return the enclosed form.

***PLEASE SIGN HERE:***
I certify the information provided is complete to the best of my knowledge.

Member Signature: _____ Date: _____

Home Telephone Number: _____ Work Telephone Number: _____

Sincerely,

COORDINATION OF BENEFITS DEPARTMENT

COB-A

**Blue Cross and Blue Shield of Nebraska**
Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 3248 • Omaha, Nebraska 68180-0001
Omaha 390-1840 • Toll Free 800-462-2924
Omaha Fax 402-392-4126

BLUE CROSS AND BLUE SHIELD OFFICE USE ONLY

# Coordination of Benefits Information Request

*Only complete if you or your dependents have other insurance*

Blue Cross and Blue Shield of Nebraska Member's Name (first & last) _____ Identification Number From I.D. Card _____

Street Address _____ City _____ State _____ Zip + 4 _____

Are you (member) ❑ Employed ❑ Not Employed ❑ Retired Date of Retirement _____

Is your spouse ❑ Employed ❑ Not Employed ❑ Retired Date of Retirement _____

## Other Group Health Plan Information:

Name of Policyholder (first & last) _____ Identification Number of Policy _____

Employer's Name _____ Street Address _____ City _____ State _____ Zip + 4 _____

Name of Insurance Co. _____ Address _____ City _____ State _____ Zip + 4 _____

Type of Coverage(s) ❑ Hospital ❑ Physician/Medical ❑ Prescription Drug ❑ Dental ❑ Effective Date _____

Type of Coverage ❑ Single ❑ Family Insured's Social Security Number _____

| Name of family members covered by this plan | Relationship to policyholder | Social Security Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Divorce:** If your child(ren) are covered by more than one group policy, please list each.

If the above other insurance is provided as the result of a divorce decree, who is responsible for coverage?
❑ Mother ❑ Father
By court order? ❑ Yes ❑ No
If there is no court order, who has custody? ❑ Mother ❑ Father

**Signature:** I certify the information provided is complete to the best of my knowledge.

Member signature _____ Date _____

Home telephone number _____ Work telephone number _____

***Please return this form in the enclosed envelope.***